Coordinating health & health care for a thriving Kansas

KHPA™

KANSAS HEALTH POLICY AUTHORITY

Upon completion, please send this form to:

Kansas Health Policy Authority
ATTN: Privacy & Compliance Officer
Landon State Office Building
900 SW Jackson St, Room 900
Topeka, KS 66612

In regards to:

Client Name: _____

Client ID or SSN: _____

Authorization for Release of Protected Health Information

Please fill in ALL blanks

I [_____] hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization (*or class of persons*) authorized to provide the information:

_____

_____

2. Specific person/organization (*or class of persons*) authorized to receive and use the information:

_____

_____

3. Specific and meaningful description of the information:
Please describe the information you wish KHPA and SRS to disclose, for example:

☐ Written, electronic and oral information related to eligibility for benefits for the time period commencing on _____ date and continuing through _____ date.

☐ Written, electronic and oral information including claims, reports, and other documents related to claims for benefits for an injury or illness commencing on ____ date and continuing through _____ date.

☐ Written, electronic and oral information relating to payment or lack of payment of benefits to [name of health care provider] for services rendered on _____ date.

☐ Other: _____

_____

4. Purpose of the request:

   Please state the purpose of the request below. [For example, to discuss my benefits with the Benefits Administration staff so that I can better understand my benefits.] If you do not wish to state a purpose, please state, "At the request of the individual."

   _____

   _____

5. Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the person/organization listed in number 1 above in writing at [list address to which revocation must be delivered]. I understand that the revocation is only effective after it is received and logged by the person/organization listed in number 1 above. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.

7. I understand that I am entitled to receive a copy of this authorization.

8. I understand that this authorization will expire on (insert an expiration date. If no date is inserted, the authorization will expire 12 months from the date entered in 9).

   _____

   _____

9. KHPA will not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.

   _____ _____

   Signature of Individual Date

   If a Personal Representative executes this form, that Representative warrants that he/she has authority to sign the form on the basis of:

   _____

   _____

   _____

   This authorization reflects the requirements of 45 CFR § 164.508 (August 14, 2002).